11. FAMILY PLANNING

Goal

Make all pregnancies in Kentucky intended pregnancies.

Terminology

Brown Bag Program: Method of condom distribution in which condoms are available in brown bags at community sites for pick up by anyone without any identification required.

Contraception: The means of pregnancy prevention. Methods include permanent methods (i.e. male and female sterilization) and temporary methods (i.e. barrier, hormonal and behavioral).

Family planning: The process of establishing the preferred number and spacing of one's children, selecting the means by which this is best achieved, and effectively using that means.

"Highly effective contraceptives": Those methods of contraception which demonstrate the greatest level of success with typical use.

Intended pregnancy: A pregnancy that a woman states was wanted at the time of conception, irrespective of whether or not contraception was being used.

Title X: A grant program for family planning services offered through the Office of Population Affairs, enacted in 1970 by Congress as the Family Planning Services & Population Research Act.

Unintended pregnancy: A general term that includes pregnancies that a woman states were either mistimed or unwanted at the time of conception (and not at the time of birth).

Mistimed conceptions: those that were wanted by the woman at some time, but which occurred sooner than wanted.

Unwanted conceptions: those that occurred when the woman did not want any pregnancy then or in the future.

Women at risk of unintended pregnancy: Women who (1) have had sexual intercourse in the previous 3 months; (2) are not pregnant, seeking pregnancy, or postpartum (pregnancy ended within 2 previous months); and (3) are not sterile (surgically or nonsurgically).

Overview

In 1997, 925,570 Kentucky women were of childbearing age (15 – 44 years). Of these, 18 percent lived in poverty and 18 percent had no health insurance. The pregnancy rate in Kentucky is 86 pregnancies per 1000 women ages 15 – 44 years, 58 per 1000 ending in births and 11 per 1000 ending in abortions. Of these pregnancies, 29 percent are to unmarried women. Women ages 15-19 years have 99 pregnancies per 1000 women of which 63 end in births and 19 in abortions. Four of ten women have an abortion at some time in their reproductive years according to the Alan Guttmacher Institute (AGI). Although the unintended pregnancy rate has declined in recent years, efforts toward making every pregnancy an intended pregnancy must not only continue but also must be strengthened. Family planning is the process for achieving this desired outcome. Women require contraceptive protection for most of their reproductive lives.

Reducing unintended pregnancies in Kentucky will have far-reaching effects in both medical and social settings. Social costs can be counted in such areas as reduced educational achievements, reduced employment opportunities, increased welfare rolls, and increased potential for domestic violence and child abuse. Medical costs include the resultant number of abortions (AGI estimates 47 percent of unintended pregnancies in publicly funded settings.), low birth weight infants, Sudden Infant Death Syndrome (SIDS), neonatal mortality, miscarriages, and follow-up treatment for "babies having babies".

Current contraceptive practice has room for improvement such as in the information people have about contraceptive methods; in their ability and motivation to act on that information to protect themselves and their partners from unwanted outcomes; and in the availability and accessibility of contraceptive services and supplies. While most people obtain contraceptive care from a private physician, access can be problematic for those who cannot afford private physicians, for those who need confidential care, or who live in areas where few private physicians are available.

The proposed family planning objectives for *Healthy Kentuckians 2010* are reflective of the Institute of Medicine (IOM) recommendations and the national *Healthy People 2010* objectives. The objectives are directed to all Kentuckians from both consumer and provider perspectives in private and public settings.

Progress Toward Year 2000 Objectives

5.1 To provide family planning medial and counseling services to 60 percent of the women determined to be in need of subsidized family planning services.

Progress toward providing family planning medical and counseling services to 60 percent of the women determined to be in need of subsidized family planning

continues. During calendar year 1998, 123,665 of the 247,157 females (50 percent) estimated to be in need of subsidized family planning were served in Title X clinics.

5.2 To reduce pregnancies among girls ages 15-17 years to no more than 50 per 1,000 adolescents.

The rate of pregnancies among girls 15-17 years old has been reduced to 50 per 1000 adolescents (1994) thus meeting this goal.

5.3 To reduce the percentage of births to teens to 12% of total births.

Progress toward reducing the percentage of births to teens continues in Kentucky. In 1996, births to Kentucky teenagers were 16 percent of total births compared to 21 percent in 1980.

5.4 To reduce the proportion of adolescents who have engaged in sexual intercourse to no more than 15 percent by age 15, and no more than 40 percent by age 17.

No recognizable progress has been made toward reducing the proportion of adolescents who have engaged in sexual intercourse to no more than 15 percent by age 15 and no more than 40 percent by age 17. The Youth Risk Behavior Survey (YRBS) in 1996 reported that 53.7 percent of Kentucky students have had sexual intercourse. Students in lower grades are more likely than students in higher grades to have had sex by age 13.

5.5 To increase to at least 90 percent the proportion of females ages 13 and older served in family planning clinics who know that alcohol, smoking and other drug use during pregnancy pose risks to the fetus.

Progress has been made toward increasing to at least 90 percent the proportion of females ages 13 and older served in family planning clinics who know that alcohol, smoking and other drug use during pregnancy posts risks to the fetus. Local health department staff assess and counsel routinely on the affects of substance abuse.

5.6 To increase to at least 60 percent the proportion of primary care providers who provide appropriate preconceptional care and counseling.

Progress continues toward increasing the proportion of primary care providers who give appropriate preconception care and counseling (Obj. 5.6). All local health departments now have preconception counseling service as part of their practice reference protocol.

2010 Objectives

11.1. (Developmental**) Increase to at least 60 percent the proportion of all pregnancies among women 15-44 that are planned (intended).**

Target Setting Method: This target was adapted from *Healthy People 2010*, using national data. Kentucky ranks 27th nationally in out-of-wedlock births. Between 1988 and 1995, the proportion of all pregnancies that were unintended dropped by 7 percentage points, from 56 percent to 49 percent. The target set assumes a continued reduction and reflects the current rates of diverse ethnicities, fostering the effort of the overarching goal to eliminate disparities.

Potential Data Source: No Kentucky data for past years are available for "intendedness" of pregnancy. A question now has been added to the Behavioral Risk Factor Surveillance System (BRFSS) to gather data through the family planning module about unintended pregnancy. Also data will be derived from births registered and abortions reported in Kentucky.

Implementation Strategy:

- Assure Kentuckians easy access to contraceptive services and supplies.
- Target hard to reach populations through outreach, education and specialized services.
- Make preconception services available to women of childbearing age.
- Provide the most effective contraceptive choice.

11.2. Decrease to no more than 7 percent the proportion of women aged 15-44 experiencing pregnancy despite use of a reversible contraceptive method.

Target Setting Method: This target was adopted from *Healthy People 2010*.

Data Source: Patient Services Reporting System (PSRS).

Implementation Strategy:

- Continue availability of funding for family planning services.
- Continue to educate sexually active individuals on the efficiency of various contraceptive methods via clinic and educational programs.

As in the national objective, the public health benefits of improved contraceptive practices are enormous. Whether fertile men and women who are sexually active and do not want to get pregnant experience an unintended pregnancy is a function of their choice of contraceptive methods and how effectively they are able to use them. Poor or nonexistent contraceptive use is one of the main causes of unintended pregnancy. Unintended pregnancy occurs principally among two

groups which are women using reversible contraception because of a contraceptive failure or improper use and women using no contraception. Decreasing the proportion of sexually active individuals using no method and increasing the effectiveness with which people use contraceptive methods would do much to lower the unintended pregnancy rate.

From data in the PSRS, trends in Kentucky show an increase in the more highly effective methods of contraception. The use of Depo Provera, with an effective rate of 99.7 percent, has increased from 11 percent usage in 1997 to 15 percent in 1998. Usage of barrier methods has also shown an increase, which may suggest that concerns about HIV and other sexually transmitted diseases are changing patterns of methods used.

11.3. Increase to at least 95 percent the proportion of all females aged 15-44 at risk of unintended pregnancy who use highly effective contraception.

Target Setting Method: The *Healthy People 2000* goal of 95 percent has been retained, but the focus of this objective has been modified from the prior national objective to shift the measure from any contraceptive choice to "use of highly effective contraceptives". Increasing the use of the most effective contraceptive choices would dramatically reduce the occurrences of unintended pregnancies.

Data Sources: Regional Network for Data Management and Utilization; Patient Service Reporting System (PSRS).

Implementation Strategy:

- Continue school and community based teen pregnancy prevention through Title X Special Initiative.
- Increase the percentage of funding for highly effective contraceptive choices.
- Expand clinic hours and nontraditional family planning, exploring opportunities in school based clinics.
- Promote implementation of preconception counseling within the education system and include explanations of highly effective contraceptive methods.
- Continue Brown-Bag Program and look for expansion opportunities in community settings.
- Ensure that all females of childbearing age without permanent contraception be offered Family Planning services in the health department when they present for any service.
- Pursue the Medicaid Waiver to increase the number of people eligible for reimbursement of Family Planning services.

11.4. Increase to 100 percent the proportion of Title X family planning clinics that provide, either directly or through referral, postcoital hormonal contraception.

Target Setting Method: This objective is adapted from *Healthy People 2010*.

Data Source: Patient Service Reporting System (PSRS).

Implementation Strategy:

- Provide health department staff with ongoing education about emergency contraception.
- Offer consumer information via new routes such as Nurse Hotline, etc.

As with the national objective, postcoital administration of emergency contraceptive pills (ECP) after unprotected intercourse is an effective means of reducing unintended pregnancy. ECP is estimated to reduce the risk of subsequent pregnancy by 75 percent. The method, however, remains not widely available to the public. Several developments in recent years have formalized recognition within the medical community of ECP as an effective means of birth control. In 1996, the American College of Obstetrics and Gynecology issued practice patterns for emergency oral contraception. That document also identifies challenges to the more frequent use of this therapy including physician awareness of the method, public awareness of the method's availability, and access by patients to a physician who will prescribe the method. In 1997, the Food and Drug Administration issued a public notice in the Federal Register announcing that certain regimens of oral contraceptives are safe and effective for ECP when initiated within 72 hours after unprotected intercourse and invited drug companies to submit packaging and labeling for oral contraceptive products specifically for emergency use.

11.5. (Developmental) Increase male involvement in pregnancy prevention and family planning as measured by the increase with which health providers provide outreach, education, or services to males.

Potential Data Sources: Title X male involvement numbers from the PSRS; Youth Risk Behavior Surveillance System (YRBSS) data.

Implementation Strategy:

- Explore and monitor the level of federal funds available to involve males in family planning.
- Seek additional funds to educate and promote male involvement.
- Develop an educational program to provide responsible and comprehensive sexuality education that includes information about contraception aimed specifically at the male role in pregnancy prevention, including legal responsibilities of parenting
- Develop a public awareness campaign promoting the services offered.

This objective is adapted from *Healthy People 2010* based on the lack of male participation in Title X programs and the number of unintended pregnancies, as measured by out of wedlock births.

11.6. Reduce pregnancies among females ages 15-17 to no more than 45 per 1,000 adolescents.

Target Setting Method: based on *Healthy People 2010* guidelines. Pregnancies are measured by adding births, stillbirths, and terminations (abortions). This does not include out-of-state abortions, miscarriages, etc. Abortion data are not broken down in the same increments as births (i.e. under 15, 15-17, and 18-19). Instead, they are grouped as under age 15, 15-19, etc., disallowing accurate comparisons.

In 1997, the pregnancy rate for females ages 15-19 rather than ages 15-17 was 67.4 per 1000 females. This number included births, stillbirths, and terminations done in Kentucky. The birthrate for those adolescents 15-17 in 1997 was 35.3 per 1000.

Since the birth rate for females ages 18-19 is substantially higher (97.4 per 1000, 1997) than the 15-17 age group (35.3, 1997), it follows that the abortion rates would vary in a similar pattern. This is the information used to select the target for female adolescents ages 15-17.

Data Sources: Vital Statistics System; PSRS.

Implementation Strategy:

- Offer most effective contraceptive choice to all Kentuckians in need of family planning services.
- Co-locate services with social programs to enhance accessibility.

11.7. Increase by at least 10 percent the proportion of sexually active individuals, ages 15-19, who use barrier method contraception with or without hormonal contraception to prevent sexually transmitted disease and prevent pregnancy.

Target Setting Method: The Kentucky YRBSS data show 15 percent of male and 11 percent of female students in the 9^{th}, 11^{th} and 12^{th} grades, who had sexual intercourse during the prior three months, were using birth control pills during the last sexual intercourse. Also, 66 percent of male and 50 percent of female students, who had sexual intercourse during the prior three months, used a condom during the last sexual intercourse.

Data Sources: YRBSS; PSRS

Implementation Strategy:

- Increase student education for prevention of sexually transmitted infections prior to the 10th grade.
- Make anonymous condom distribution more accessible.

11.8. (Developmental) Increase to 95 percent the proportion of public and private elementary, middle/junior and senior high schools that require instruction on human sexuality, pregnancy prevention, STD prevention, and HIV prevention that provide students with information and skills related to abstinence and contraceptive use.

Target Setting Method: This target is based on the current national percentages of schools teaching required courses in the fields identified. The percentages are as follows:

Schools teaching a required course in:	Middle/Junior High	Senior High
HIV Prevention	78.6	90.0
Human Sexuality	78.0	81.2
Pregnancy Prevention	56.8	77.1
STD Prevention	77.0	88.5
Teachers teaching "Contraceptive Methods"	32.6	61.5
"Reasons for Choosing Abstinence"	61.3	71.3

Potential Data Source: School Health Policies and Programs Study (SHPPS); the Centers for Disease Control and Prevention (CDC) for national data estimates.

Implementation Strategy:

To increase the age appropriate level of knowledge of students concerning human sexuality and methods to prevent pregnancy and sexually transmitted diseases:

- Increase the number of questions on the statewide KIRIS tests that relate to pregnancy and STD prevention.
- Urge policy makers to require courses in human sexuality that are factually based and age appropriate at each level of elementary, middle, and high school.
- Increase media attention to educate parents about the importance of communication with their children concerning sexuality issues before they become sexually active and to encourage education administrators to include health education on sexuality issues in their school's curricula.

School health profiles for 1996 indicate that Kentucky was below the national median for instruction in three program areas:

	Kentucky	National
Pregnancy Prevention	78.5	84.9
HIV	89.1	97.2
Sexually Transmitted Diseases	83.8	93.8

References

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